REPRODUCTIVE HEALTH STRATEGY FOR THE UKRAINE

1999-2002

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ACRONYMS AND FOREIGN TERMS

AIHA	American International Health Alliance
AVSC	Access to Voluntary and Safe Contraception International
CA	Cooperating Agencies
CDC	Centers for Disease Control and Prevention
CIDA	Canadian Agency for International Development
CMS	Commercial Market Sector Project
CYP	Couple year protection
DHS	Demographic and Health Survey
DMPA	Depo Medoxy Progesterone Acetate
DST	Office of Democracy and Social Transition
feldsher	Medical attendant
FHI	Family Health International
G/PHN/HN/ HIV–AIDS	Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Health and Nutrition, HIV–AIDS Division
GOU	Government of the Ukraine
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IEC	Information, education and communication programs
IPPF	International Planned Parenthood Federation
IDU	Intravenous drug users
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PCS	Johns Hopkins University, Population Communications Services
MCH	Maternal and child health
MOH	Ministry of Health
NFPP	National Family Planning Program
NGO	Nongovernmental organization
OYB	Official year budget
PATH	Program for Appropriate Technology in Health
PHC	Primary health care
RFP	Request for proposal
RH	Reproductive health
SDP	Service Delivery Points
SO	Strategic Objective
SOMARC	Social Marketing for Contraceptives Project
STD	Sexually transmitted disease
TFR	Total fertility rate
UFPA	Ukrainian Family Planning Association
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USMR	Ukrainian Surveys and Market Research
WHO	World Health Organization
WRHI	Women's Reproductive Health Initiative

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EXECUTIVE SUMMARY

Since 199l, the Ukraine has been progressing from a centrally controlled economy and authoritarian political system to a pluralistic society and market-oriented economy. This transition has been slow and difficult. All economic sectors, including the health sector, have dramatically reduced their funding levels.

With a population of 50.5 million in 1998, the Ukraine is second only to Russia among Eastern European countries. The rate of population growth is negative at –0.6 percent. The decreasing size of the population is attributed to a declining standard of living that has caused a steady decline in fertility in both urban and rural areas and a steady increase in mortality rates in urban and rural areas. The total fertility rate (TFR) has declined steadily from 1.9 in 1989 to 1.3 in 1997.

As in most of the republics of the former Soviet Union, induced abortion has been a primary means of fertility control in Ukraine. The number of abortions per 1,000 women of childbearing age has decreased from 83 in 1990 to 47 in 1997. Despite the declining abortion rate, it remains one of the highest in the world when compared with rates in France and the Netherlands, which are 15 and 6, respectively.

A reproductive health survey will be carried out in mid−1999 with assistance from the Centers for Disease Control and Prevention (CDC) that should provide reliable data on attitudes and practices related to contraception as well as other aspects of women's health. Based on the "Health-1996" survey, more than half of Ukrainian women who use contraceptives use a modern method (intrauterine device [IUD], condom, pill, diaphragm, and chemical preparations). The IUD is the most popular, with 24 percent of women using this method. About 60 percent of women who use contraceptives report that the IUD or condoms are the most convenient and reliable methods.

Since 1993, the number of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) cases in the Ukraine has risen sharply, and the country is facing a serious epidemic. While the number of HIV−infected individuals was 5,422 in 1996, this number has increased to a reported 100,000 in April 1999. The rapid increase is predominately among intravenous drug users (IDU), but increasingly among other groups exposed to HIV through sexual contact.

The Government of the Ukraine (GOU) has a National Family Planning Program (NFPP); however, it has not yet provided any funding for the program. Oblasts were given the responsibility for implementing the program without any funding. Various donors and international organizations have provided assistance in support of the program's objectives. Currently in the Ukraine, reproductive health services appear to be readily available at most hospitals and polyclinics at the oblast, rayon and city levels. At the rural level, services are limited since nurses, feldshers, and midwives, who cannot

insert IUDs, staff them. While services appear to be readily available, the quality of reproductive health services should be improved.

The U.S. Agency for International Development (USAID) has provided assistance to improve health care in the Ukraine in the following areas: women's reproductive health, health care financing and service delivery reform, infectious disease control, and health surveillance and information.

The sector strategy presented here builds on past and current USAID assistance and also reflects the current environment surrounding health and reproductive health care in the Ukraine. The first recommendation is that reproductive health (RH) continue to be a priority and that there be three priority areas within reproductive health: family planning, abortion prevention, and prevention of sexually transmitted diseases (STDs) and HIV/AIDS. Also, the Mission should consider reviewing its Health Strategy in the next 4–6 months to take advantage of new information that will be available to develop a fully integrated health and RH strategy. An integrated strategy would give the Mission a clear idea of the entire health sector and allow it to sharpen its focus on areas where the integration of reproductive health into health programs is needed and appropriate.

The strategic approach for the three priority areas in RH identified above involves continued engagement of the public sector and strengthening the private sector. To promote family planning and prevent abortion, recommendations are made for policy development (in reproductive health and also more general health policy), for additional training to fill gaps in RH training efforts and reproduction, and possibly development of information, education, and communication (IEC) materials. Work with the private sector is envisioned both in terms of RH (specifically, family planning) and health care delivery in general. USAID/Kiev and the USAID/Washington Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Health and Nutrition, HIV–AIDS Division (G/PHN/HN/HIV–AIDS) are currently drafting a proposal that may be the basis for the Mission's future work with both the public and private sectors in preventing STD/HIV/AIDS.

Numerous cooperating agencies (CAs) and donors are working in the development of policies, regulations and laws in the health and reproductive health areas. It is recommended that the Mission establish a policy coordination committee to coordinate activities in the policy area and develop a policy dialogue agenda for discussions with the government. The Mission needs to ensure that the GOU understands the issues and ramifications of its decisions in the health sector. It is also recommended that the Mission expand its policy activities to the oblast level. The POLICY project could assist the Mission with these activities.

The problem of HIV/AIDS in the Ukraine is serious. It is recommended that USAID/Kiev design an HIV/AIDS project with the GOU. The project should be based upon an analysis of the current needs, gaps and activities of other donors and organizations involved in HIV/AIDS in the Ukraine. It appears that an array of activities is being carried out in the Ukraine with little or no coordination. It is suggested that the project include a policy component to assist the GOU in addressing the issue of

HIV/AIDS and a social marketing component to make inexpensive, easily accessible condoms available.

In the private sector, it is recommended that the Mission assist in strengthening the delivery of services. It is suggested that the new Commercial Market Sector (CMS) project be used to assist the GOU to: 1) improve the policy, regulatory, and legal environment and administrative practices constraining the commercial market sector, and 2) rationalize its mix of public/private resources in the delivery of health care services. The project would support the development of private delivery networks and test private health care financing mechanisms by working with private associations, such as the various private physicians' associations in the Ukraine, nongovernmental organizations (NGOs), and the commercial and nonprofit sectors.

RECOMMENDATIONS

Recommendation No. 1: Reproductive health should continue to be a priority for USAID assistance in health and there should be three priority areas within reproductive health: family planning, abortion prevention, and prevention of STD/HIV/AIDS.

Recommendation No. 2: The USAID Strategic Plan for the Ukraine, Strategic Objective (SO) 4.1, Improved Health Care Service Delivery, should be revised to include reproductive health as a specific component and several of the performance indicators suggested in section III (of this report) should be considered for adoption in the plan. It is also recommended that the Mission review its proposed Health Strategy in the next 4–6 months to take advantage of new information that will be available as other donors clarify their priorities for health assistance and to develop a fully integrated health and RH strategy. (If the Mission approves this recommendation, it is suggested that this reproductive strategy only be considered a working draft and funds not be expended on having it edited or reproduced for wide distribution.)

Recommendation No. 3: The Mission should expand the scope of work for the POLICY project to include the development of a policy agenda for the Mission, working at the oblast level, and the establishment of a policy coordination committee. The duration of these activities should be at least three years.

Recommendation No. 4: The Mission should consider conducting a training needs assessment.

Recommendation No. 5: The Mission should consider funding the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) for an additional year to assist the GOU in incorporating reproductive health and family planning into 1) the curriculum of the refresher institute of family medicine physicians and 2) the pre-service curriculum for nurses and midwives.

Recommendation No. 6: The STD/HIV/AIDS strategy currently being developed by USAID/Kiev and USAID/Washington should consider the programs of other donors, involve the GOU in the design of activities, include a policy component, and consider a condom social marketing activity. USAID/Kiev should procure the excess USAID/Washington condoms for use in the HIV/AIDS program in the Ukraine.

Recommendation No. 7: The Mission should conduct an official year budget (OYB) transfer to the CMS project for 1) conducting an assessment of the potential for the delivery of health care services in the private sector, 2) continuing the training of pharmacists, and 3) reproducing IEC materials.

Recommendation No. 8: USAID/Kiev should consider approaching the United Nations Development Programme (UNDP) about the formation of a donor working group on health.

I. SECTOR OVERVIEW

A. BACKGROUND

Since 1991, the Ukraine has been progressing from a centrally controlled economy and authoritarian political system to a pluralistic society and market-oriented economy. This transition has been slow and difficult. With the advent of independence, all economic sectors, including the health sector, have dramatically reduced their funding levels. The constitution of the Ukraine reiterates in Article 49 that health care should be available at no cost to all citizens within the existing network of state-run facilities. However, in reality, the current health budget only covers salaries and individuals must buy their medications and pay unofficially for services.

The health sector of the Ukraine has all the structural inefficiencies (as well as the benefits of universal access) that are the hallmarks of the former Soviet health care system. These inefficiencies include a concentration of financing and delivery of care at the hospital level, overcapacity of hospital facilities, centralized budgeting and financing and a top-down approach to administration, lack of incentives for facilities and providers to ensure quality and responsiveness to consumers, and lack of patient choice and responsibility for health care.

B. STATUS OF POPULATION PARAMETERS AND REPRODUCTIVE HEALTH

With a population of 50.5 million in 1998, the Ukraine is second only to Russia among Eastern European countries (State Committee of Statistics, 1998, and Cabinet of Ministers of the Ukraine and Ministry of Health of the Ukraine, et al., 1997).[1] The majority (68 percent) of the population lives in urban areas. Ukrainians are the largest ethnic group, constituting 73 percent of the population, followed by Russians and others at 22 and 5 percent, respectively.

The rate of population growth is negative at -0.6 percent. The phenomenon in the Ukraine's vital rates of the number of deaths exceeding the number of births has occurred since 1991, although immigration to the Ukraine in the first years following independence in 1991 compensated for the deficit in vital rates. However, the absolute size of the population began to decrease in 1993, when the flow of immigrants ceased. The decreasing size of the population is attributed to a declining standard of living that has caused a steady decrease in fertility rates in both urban and rural areas and a steady increase in mortality rates in urban and rural areas. Rising mortality rates are due not only to an aging population but also to higher rates of infant mortality and excess mortality among men 20–50 years old. The level of infant mortality has increased in the Ukraine from 12.8 in 1990 to 14.0 in 1997 (Cabinet of Ministers, 1997, 1998). This

[1] The 1997 report, The Health of Women and Children in the Ukraine, is based on state and sector statistical information and also on the results of a "Health-1996" survey conducted by the Kyiv International Institute of Sociology.

compares with 17 in Russia, 20 in Moldova, and 5.1 in France (Population Reference Bureau [PRB], 1998).

Fertility and Marriage

Prior to independence, fertility in the Ukraine was below replacement level.[2] The TFR was 1.9 in 1989 for the nation, although the urban TFR was 1.8 and the rural rate was still above the replacement level at 2.4. The TFR has declined steadily, reaching 1.1 for urban areas and 1.8 in rural areas in 1996. Data on desired family size from the "Health-1996" survey indicate that women want an average of about two children (the actual number is 1.9 [Cabinet of Ministers, 1997, table 3.4]). This means that actual fertility is lower than desired fertility among Ukrainian women, which is most likely related to the deteriorating living conditions.

The poor social and economic conditions have also affected marriage and other aspects of family life. The marriage rate has declined since independence, and the divorce rate has increased, especially in urban areas, although most Ukrainians (87 percent) live in families. According to the 1997 report, there is an increasing proportion of childless families (19 percent of families had no children in 1996, but no comparative data are given) and delayed childbearing (no data are given). In addition, the percent of out-of-wedlock births of all births in urban areas has increased from 10.1 in 1989 to 15.2 percent in 1997 (State Committee of Statistics, 1998, p. 47).

Maternal Mortality and Abortion

In 1992, the overall level of maternal mortality was 31.3 deaths per 100,000 births compared with 21.0 in Central and Eastern Europe and 7.4 in European Union countries (Cabinet of Ministers, 1997, table 2.9). The maternal mortality rate was 25.1 in 1997 for the country as a whole, but there was considerable variation among the oblasts (State Committee of Statistics, 1998, p. 47). The leading causes of maternal mortality are unrelated to pregnancy (referred to as extragenital pathologies), such as cardiovascular problems. The 1997 report suggests that 20 percent of such cases were complicated because of inadequate diagnosis and care.[3]

Based on 1996 data, abortion appears to remain an important cause of maternal death; 23 percent of all maternal deaths were attributed to abortion (both safe and unsafe) in 1996. The State Committee of Statistics in 1998, however, reported that, for 1997, abortion was the cause of only 9 percent of maternal deaths (p. 51). This large drop calls into question one of these numbers. About 5 percent of all abortions are performed illegally outside medical institutions; such unsafe abortions result in three times the mortality of safe, legal abortions. There has been a steady decline in the number of abortions in recent years.

[2] Replacement-level fertility is the level of fertility needed for a cohort or age group of women to have enough daughters to replace themselves in the population. A total fertility rate (TFR) of 2.1 is considered to be replacement level.

[3] These problems were attributed to errors by midwives. The report cited improvements in maternal mortality in Zhytomyr oblast where teams of midwives, therapists, and pediatricians were working together.

The number of abortions per 1,000 women of childbearing age has decreased from 83 in 1990 to 47 in 1997 (State Committee of Statistics, 1998, p. 173). Despite the declining abortion rate, it remains one of the highest in the world when compared with rates in France and the Netherlands, which are 15 and 6, respectively. The ratio of abortions to live births in the Ukraine is 140 to 100—a level far above other Eastern European countries, with the exception of Russia, where the ratio is 180 to 100.

In 1997, the levels of abortion varied considerably among oblasts, from a high of 74 in Zaporizhzhia to a low of 29 in Lviv. Several factors may account for the variation in the abortion rates, including traditional values and access to contraception and abortion. Also, Zaporizhzhia is a very industrial oblast and Lviv is more conservative and ethnically unified, as opposed to the more mixed ethnic composition found in other oblasts. While the official number of abortions has declined, the "Health-1996" survey showed that the number of women pregnant for the first time who are having abortions has risen. In 1996, 14 percent of women aborted their first pregnancy (about 18 percent in urban areas and 13 percent in rural areas). The reasons given by these women for aborting were material circumstances (47 percent) or housing problems (26 percent). Furthermore, about 17 percent of all women having abortions did so without any anesthesia, and about 44 percent unofficially paid for the abortion.

Contraception

Based on the "Health-1996" survey, there is a limited amount of published information on contraception (Cabinet of Ministers, 1997, table 7.3 and pp. 70–71), and this information may have some inconsistencies. A reproductive health survey will be carried out in mid–1999 with assistance from the Centers for Disease Control and Prevention (CDC) that should provide considerably more information on attitudes and practices related to contraception as well as information on other aspects of women's reproductive health.[4] According to the 1996 survey, 11 percent of women prefer not to use any type of contraception, although the reason for this attitude is not given. Table 1 on the following page shows the distribution by type of contraceptive method used. (It is assumed that this table refers only to women who are currently using contraception and that women who are not using a method are not included in the table.)

Table 1
Percent of Contraceptive Use by Method Among Women Using Contraception, 1996 (rounded to the nearest whole number)

METHOD	URBAN	RURAL	TOTAL
IUD	25	22	24
Condom	22	15	20
Rhythm	21	17	20
Withdrawal	15	22	17

[4] The reproductive health survey will include information on fertility, abortion, pregnancy, contraception, young women's sexual experience, maternal and child health, sexually transmitted diseases, and communication habits, preferences, and attitudes (television viewing, radio listening, and newspaper reading).

Pill	7	3	5
Chemical preparations	4	3	4
Breastfeeding	1	2	2
Diaphragm	.05	.2	.1
Injected implants	.05	.2	.1
Sterilization*	—	—	—
Total**	95	84	92

Source: Cabinet of Ministers of the Ukraine and Ministry of Health of the Ukraine, et al., 1997, table 7.3

* Sterilization was legalized in 1994; 50 women had been sterilized subsequently (Cabinet of Ministers, 1997, p. 71).
**It is not clear why these numbers do not total 100 percent.

Based on table 1, over half of Ukrainian women who are using contraceptives use a modern method (intrauterine device [IUD], condom, pill, diaphragm, and chemical preparations). Among such women in urban areas, 58 percent use modern methods compared to only 43 percent of rural women. About 60 percent of women who use contraceptives report that the IUD or condoms are the most convenient and reliable methods. Other modern methods, such as pills, the diaphragm, and injected implants, are not so favorably perceived.

Typical of countries in the former Soviet Union, women in the Ukraine resort to abortion when they have an unintended or unwanted pregnancy. Hence, abortion has been and continues to be a method of controlling fertility. From the data available, it is not clear whether the decline in the number of abortions between 1990–1996 is related to an increase in the use of contraception (particularly the use of more effective methods) and/or more careful use of less reliable methods.

Maternal Morbidity

Several health problems suggest a worsening of maternal health status and welfare. Among pregnant women, high rates of anemia are increasingly prevalent. The percentage of pregnant women with anemia has increased from 8.7 percent in 1990 to 32.1 percent in 1996, according to the Ukrainian Ministry of Health (MOH). Increasing prevalence of anemia and a noted increase in cardiovascular problems are attributed to an increase in complications at the time of delivery and a lower percentage of normal deliveries (only about a third of deliveries are registered as normal, according to the "Health-1996" survey). The frequency of miscarriage has also increased from 6.8 percent in 1990 to 12.1 percent in 1990 (Cabinet of Ministers, 1997, figure 7.4). These trends are associated with a deteriorating state of pregnant women's health and the quality of medical care. Until more recent information is available, it cannot be determined if these conditions have improved since 1996.

Infertility is also cited as a problem among Ukrainian women, and data from infertility centers show that "artificial interruption of pregnancy" is a cause of infertility among 22 percent of women being treated (Cabinet of Ministers, 1997). However, there is a question about whether the level of infertility in the Ukraine is excessive and whether

abortion is an important cause of infertility. An evaluation by Bergthold, et al., (1998, p. 15) suggests that the levels of male and female infertility may be similar to those in the United States and other parts of Europe. Furthermore, this evaluation did not find evidence that legal abortions are a major cause of maternal mortality and morbidity or that abortions are a significant cause of infertility.

Sexually Transmitted Diseases and HIV/AIDS

There has been a significant increase in sexually transmitted diseases in the Ukraine in the past decade, especially syphilis. Syphilis morbidity rates per 100,000 women rose from 3.5 in 1989 to 143 in 1997 (State Committee of Statistics, 1998, p. 175).

Since 1993, the number of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) cases in the Ukraine has risen sharply, and the country is facing a serious epidemic. While the number of HIV–infected cases was 5,422 in 1996 (76 percent were men and 24 percent were women), the number had increased to 15,986 by the end of 1997 (Russian Federal AIDS Centre, 1998) and is reported to be about 100,000 in April 1999 (Novak, 1999). The rapid increase is predominately among intravenous drug users (IDUs), but increasingly among other groups exposed to HIV through sexual contacts. The number of infected children, through perinatal transition, is also growing (337 cases in children through 1997, of which 90 percent were children born to infected mothers). The number of registered AIDS cases was 228 at the end of 1996 and 408 by 1997. The epidemic is most severe in the cities of Odessa and Mikolaiv on the Black Sea; it is increasingly reaching other parts of the country (McAlister and MacNeil, 1998).

Adolescent Reproductive Health

The status of adolescent reproductive health in the Ukraine, based on available information, suggests that the economic and social changes since independence are having deleterious effects on the health and welfare of young adults. Of the published information, some statistics are given only at one point in time while other data provide a comparison over the past few years. It is suggested that Ukrainian youths are becoming sexually active at earlier ages[5] but are not sufficiently aware of how to protect their health and prevent unwanted pregnancies. Apparently, 30 percent of sexually active teenage girls become pregnant (Cabinet of Ministers, 1997, p. 62). In 1996, the percent of births to teenagers under age 18 was 4.5, and the percent of children born to unwed mothers was 13.2 (however, the age of mothers is not specified) (Cabinet of Ministers, 1997, p. 60). There is no published information on the contraceptive practices of adolescents. Abortion rates among young women 15–17 years old decreased between 1994 and 1996, but the level of abortion among adolescents apparently remains high in comparison with countries of Western Europe (Cabinet of Ministers, 1997, p. 62). In addition, as previously mentioned, the percent of women who abort their first pregnancy has risen in recent years; it might be assumed that some of these women are adolescents.

[5] This trend is supported by data from two surveys in adjacent countries that have some of the same ethnic groups: 1996 Russia Reproductive Health Survey and Reproductive Health Survey, Moldova, 1997.

Morbidity rates among young adults for sexually transmitted diseases (STDs) have been increasing. For example, the increase in the rate of syphilis among adolescent women and men 16–18 years old has been dramatic, reaching 63.3 and 74.7, respectively, in 1996. The rates of gonorrhea have increased among this young age group as well. About 13 percent of the cases of HIV–infection are young adults, 15–19 years old, and apparently the number of cases among the 12–17 year old age group has also increased (Cabinet of Ministers, 1997). The 1997 report states that young adults seldom use condoms because they do not recognize their use as a way to prevent STDs, including HIV.

The 1997 report also states that substance abuse (alcoholism, drugs and toxic substances) among young adults has also been increasing, and such behavior is associated with greater risk of unwanted pregnancy and the spread of STDs. Information from the upcoming reproductive health (RH) survey should help clarify reproductive health issues and needs of young adults in the Ukraine, especially young women.

Trafficking of Women

Based on a recent assessment on trafficking of Ukrainian women, the Ukraine is a major source of young women being trafficked to commercial sex markets in Western Europe, the United States, the Middle East, and the Far East (Johnson, 1998). This assessment cites an estimate from the Ministry of the Interior of 400,000 Ukrainian women who have been trafficked in the past decade. The assessment calls for increased attention to the problem and points to the need for various health, counseling, and legal services as well as crisis centers and shelters to help women who are located and return to the Ukraine.

Breast Cancer

Breast cancer composes 18 percent of all female cancers in the Ukraine and has been the leading cancer among women since 1977. Incidence rates have increased from about 42 per 100,000 women in 1986 (the year of the Chernobyl accident) to nearly 50 in 1995. Breast cancer mortality has increased by more than 60 percent, from 9 women per 100,000 in 1980 to 15 in 1994, which means that about 8,000 women are dying every year from breast cancer (Doan, 1997).

C. CURRENT HEALTH AND REPRODUCTIVE HEALTH PROGRAMS

Government of the Ukraine

The government of the Ukraine (GOU) recognizes the need for health reform, and the first steps to reforming the health care system were taken in 1996 (Cabinet of Ministers, 1997, p. 38). The Ministry of Health's (MOH) concept for health reform (embodied in a bill entitled, "On Medical Insurance") states that the Ukraine will change to a health care system that will be financed from the government's budget and from insurance. The government is considering adopting a mandatory health insurance system, which assumes a market economy. Achieving such an insurance system is greatly complicated by the current economic problems confronting the country.

In 1997, the GOU allocated 3.8 percent of the gross domestic product to health, which compared with an average of 7.6 percent among countries in the OCED (USAID Strategic Plan for 1999–2002). State expenditures on health, however, have apparently decreased in recent years. As a result, state medical facilities have experienced acute shortage of medicine and equipment and at times have been unable to pay staff. Furthermore, the lack of experience in carrying out health reform has also affected health care with the result of deteriorating quality of care.

The 1997 report recognizes the need to reorganize the health care system to provide more efficient and cost-effective health services based on a hierarchical pyramid structure of primary, secondary and tertiary care. Furthermore, a basic package of health services should be available for all under a reformed health care system. Such services would include the health care of children, family planning, and treatment of various infectious diseases, such as tuberculosis and STDs (Cabinet of Ministers, 1997, pp. 38–42).

The GOU has taken a number of steps at the national level aimed at improving the health of mothers and children. The government has institutionalized the rights of women and children (in the *Principles of Health Legislation of the Ukraine*), improved the system of maintaining reproductive health, and initiated programs to help youth. These principles cover the right to: 1) sterilization "performed in relevant medical establishments at the desire and with the free consent of the patient in accordance of MOH medical indicators," 2) abortion "performed in specific medical establishments up until the 12th week of pregnancy at the desire of the woman and up until the 28th week in the event of certain social or health conditions," and 3) contraceptives and family planning services by teenagers. According to the 1997 report, progress in implementing these reforms is slower than is desirable (Cabinet of Ministers, 1997).

In 1995, the Cabinet of Ministers adopted a National Family Planning Program (NFPP) to support family planning and reproductive health services. This program (intended for 1995–2000) anticipates that various GOU ministries would be involved, including Health, Education, Family and Youth Affairs, as well as international organizations. It calls for widespread provision and promotion of modern contraception and reduction in the number of abortions. The GOU has not yet funded the program. Oblasts have been given responsibility for implementing the program without any funding. Each oblast has established family planning centers. The evaluation team visited two family planning centers at the rayon level that appeared to be well staffed. At the rural level, nurses and midwives provide reproductive health counseling. Since all IUDs must be inserted by obstetricians/gynecologists, clients must wait for the obstetrician/ gynecologist to visit the rural center, usually once or twice a week, or go to the nearest rayon polyclinic, women's consultation clinic, or hospital. Various donors and international organizations have provided assistance in support of the program's objectives. Recent efforts at policy dialogue on reproductive health are encouraging signs that the GOU may begin to carry out this program.

Primary responsibility for HIV/AIDS control efforts rests with the National Committee for the Prevention of Drug Abuse and AIDS; however, the government has not played a

major role in either prevention or treatment. While developing informational and promotional programs using mass media is seen as a national priority, sufficient resources are not available to do so. Health care for HIV–positive persons is given in special inpatient and outpatient facilities because most physicians do not feel comfortable caring for these patients.

U.S. Agency for International Development (USAID)/Kiev Health Programs

USAID/Kiev has provided assistance to improve health care in the Ukraine in the following areas: women's reproductive health, health care financing and service delivery reform, infectious disease control, and health surveillance and information. Comprehensive women's health that encompasses more than reproductive health has also been part of the assistance and includes breast care.

Women's Reproductive Health

Beginning in fiscal year 1995, USAID provided funds to the Ukraine under a Congressional earmark to the newly independent states (NIS) region, to reduce the number of abortions by encouraging the use of modern contraception. This assistance was provided as a special initiative, entitled Women's Reproductive Health Initiative (WRHI). Subsequently, the focus of the assistance has broadened to include improving maternity care and preventing STDs.

The principal strategic objectives of the WRHI are:

- establishment of demonstration sites for training and delivery of family planning services,
- institutionalization of reproductive health training,
- increased public awareness of family planning,
- improved policy environment for family planning and reproductive health,
- increased availability of contraceptives, and
- promotion of family-centered maternity care and early breastfeeding.

The WRHI has been implemented through six cooperating agencies (CAs) including: Access to Voluntary and Safe Contraception International (AVSC); The Futures Group International (both the POLICY and Social Marketing for Contraceptives [SOMARC] projects); the Johns Hopkins University (two projects: Johns Hopkins Program for International Education in Reproductive Health [JHPIEGO] and Population Communications Services [JHU/PCS]); John Snow Incorporated (MotherCare Project); Centers for Disease Control and Prevention (CDC); and, Georgetown University's Institute for Reproductive Health.

Accomplishments by each strategic objective are (Bergthold, et al., 1998):

- Demonstration sites were established at three regional maternal and child health (MCH) centers in Donetsk, Odessa and Lviv. Family planning services and training are being provided at each.

- Reproductive health training is now part of the ongoing program of refresher training required of all obstetricians/gynecologists every five years. The curriculum includes three days on family planning, including clinical and natural methods, and uses new training methods and materials.

- National reproductive health guidelines were adopted and disseminated in 1999.

- Public information, mainly in the three oblasts where WRHI has been active, has increased through the production and dissemination of two pamphlets and two videotapes on contraceptive methods. Also, WRHI supported the first Ukrainian National Family Planning Week, held in May 1997.
- Increased awareness of the need for national level policy dialogue, with the leadership of the head of MCH in the MOH, is leading to the formation of a multisectoral reproductive health policy group that will spearhead the development of a national reproductive health policy and increase both political and financial support to the National Family Planning Program (NFPP).

- Contraceptives (pills, IUDS, and Depo Medoxy Progesterone Acetate [DMPA]) have been provided to selected sites in the Ukraine. (USAID has not yet provided condoms either for family planning or for STD/HIV/AIDS prevention.)

- Family-centered maternity care units, including postpartum rooming-in of babies with their mothers, were established in each demonstration site. Subsequently, in 1996, a national MOH order directs all delivery units to implement the postpartum rooming-in policy.

- SOMARC trained pharmacists in Odessa.

The Johns Hopkins University (PCS project) and Family Health International (FHI) are carrying out two more recent activities. The first is a postpartum and postabortion initiative implemented by PCS that is intended to increase awareness and use of family planning among women through the training of doctors and midwives in the Crimea and Kharkiv oblasts and a mass media campaign on postpartum and postabortion services. The second is an HIV/AIDS prevention initiative implemented by PCS and FHI aimed at developing a nongovernmental organization (NGO) network that delivers HIV/AIDS information and services to high-risk groups (intravenous drug users [IDUs], commercial sex workers, and the partners of both groups).

Health Financing and Service Delivery Reform

The following three USAID programs have addressed different aspects of health financing and service delivery reform.

The **Zdrav*Reform* Program** was active in the Ukraine from 1994 through early 1999, providing training and technical assistance through a CA in health (Abt Associates, Inc.) to improve consumer-focused, quality primary care. The assistance was also aimed at maximizing scarce health resources through financial and management reform and private sector initiatives, and also by restructuring health facilities and care to improve patient outcomes and efficiency. Two new primary care ambulatory facilities were established in Lviv, and doctors serving these facilities were trained as family practitioners. In rural areas, hospital services were restructured to provide day and elder care and to include cost recovery. In Odessa, self-financing health facilities were set up that charge patients for quality services. Some private-sector groups initiated contracts with major employers to provide health services. The program also worked with the MOH on health insurance policy and licensing and accreditation of hospitals. One promising consequence of the Zdrav*Reform* Program in the Ukraine was that the specialty of family doctor was officially recognized by the MOH in December 1997. The MOH appears poised to move ahead with an emphasis on primary health care and family medicine. Also, the MOH is continuing to develop plans for accreditation of hospitals. The major failing of the project was the lack of change in policies, regulations and procedures at the national level to allow for the financing of health care. Several planned pilot projects at the oblast level were not implemented or were stopped because of legal issues.

USAID/Kiev intends to issue a request for a proposal (RFP) for a new health care financing program. The new program should begin in early 2000.

There are two phases to the program of medical partnerships: the first, referred to as **Hospital Partnerships Program,** was active in the Ukraine from 1993 through 1998, and the second, **Health Partnerships Program,** is a three-year program from September 1998 through September 2001. Both programs focus on improving the health delivery system in the Ukraine by creating institutional and professional linkages between U.S. and Ukrainian clinicians and health managers. In the first partnership program implemented by the American International Health Alliance (AIHA), six hospital partnerships have been created to update medical practices, improve quality of services, and introduce modern management approaches in particular health areas. Activities have been carried out in the following areas: infection control, neonatal resuscitation, emergency medical services, nursing education, and women's health. Accomplishments include: adoption by the MOH of national initiatives to expand program activities in the above areas; establishment of Neonatal Resuscitation Training Centers in Lviv, Kiev, Odessa, Kharkiv, and Donetsk; establishment of three Women's Wellness Centers, including breast care in Kiev, Lviv and Odessa; and, setting up three Nursing Learning Resource Centers in Odessa, Kiev, and most recently, Lviv, to improve nursing education and thereby expand nurses' clinical and administrative roles (AIHA, 1999).

The new agreement for the Health Partnerships Program, also implemented by AIHA, provides continuing support for many of the established activities (described above), much of it in terms of sustainability efforts. The program adopts a new model for health care delivery: community-oriented primary health care that is planned initially for five sites (Kiev, Lviv, Odessa, Kharkiv, and Donetsk). The new primary care centers coupled with the existing Women's Wellness Centers will be the focal point of the partnerships program assistance. In addition to continuing efforts in health areas such as breast care and infection control, additional areas are being supported, including: a) STD prevention and management; b) domestic violence; c) contraceptive technology and counseling training; d) women's health and aging; e) cervical cancer; f) mental health (especially for women at risk); and, g) adolescent risk reduction (STD/HIV/AIDS, unintended pregnancies, substance abuse, violence, and trafficking). While most of the assistance would focus on working with health providers and the health delivery system, the work plan mentions one client-oriented activity—consultation hotlines—that would be used at both Women's Wellness and primary care centers. In sum, the scope of the new Health Partnerships Program is broader than the previous agreement. Budget estimates are greatest for new partnerships for primary care centers (about 75 percent) but still maintain an important focus on women's health (15 percent of the budget) (AIHA, 1999).

Also under the new agreement, AIHA has a special component on trafficking of women. AIHA will address the issue in three areas: mental health, physical health, and training of social workers. The mental health component will assist women who return and may be suffering from depression and work on prevention of women being lured into trafficking jobs. Adolescents will be a special target for prevention. The physical health component will assist women who return with STDs. Social workers will receive special training, enabling them to work with these issues.

It should be noted that three of the four goals of the AIHA–supported Women's Wellness Centers are very similar to the Women's Reproductive Health Initiative and include preventing: 1) unintended pregnancies and abortions, 2) poor pregnancy outcomes, 3) sexually transmitted diseases and infertility, and 4) unhealthy lifestyles (AIHA, no date). The core services are: 1) family planning; 2) screening and prevention of STDs, breast and cervical cancer; 3) medical history, physicals and referrals; 4) perinatal referrals; and, 5) health education and counseling.

In response to a U.S. Congressional mandate to support a project on breast cancer, the **Breast Cancer Assistance Program** has been assisting the MOH since 1997 to strengthen its breast cancer services. The program is implemented by a USAID cooperating agency, the Program for Appropriate Technology in Health (PATH) and is being carried out at three centers: Chernihiv Oblast Oncological Hospital, Odessa Oncological Hospital, and the Breast Cancer Diagnosis Centre of the Institute of Oncology in Kiev. The program is helping to develop a comprehensive program that includes screening, diagnosis, treatment, and rehabilitation of women. This work complements that being carried out at the Women's Wellness Centers under the Partnerships Programs cited above.

Health and Infectious Disease Information and Response

From 1994 through 1996, USAID, PATH and CDC worked with the MOH to develop and implement the control strategy and helped to reverse the course of a diphtheria epidemic. The Ukraine received 32 million doses of diphtheria toxoid (Td) vaccine as well as technical assistance. Current technical assistance from PATH to the MOH is helping to improve public health surveillance and information systems, prevent outbreaks of infectious diseases and reduce the rate of such diseases, develop an adequate vaccine supply, and assist the GOU with the purchase of vaccines using the process of international tender.

Other Donors

Numerous other donors (multilateral and bilateral as well as private) have provided assistance to the Ukraine in the health area and, more specifically, in reproductive health. Current activities of other donors include the following:

- **United Nations Population Fund (UNFPA):** The current UNFPA two-year program will end in October 1999. The program supported the regional oblasts' family planning centers, trained trainers and family planning center staff, purchased information, education and communication (IEC) equipment, and provided contraceptives. A new program will be discussed with the MOH in the near future. It may include contraceptives, training of nurses and midwives in reproductive health, and IEC materials.

- The **International Planned Parenthood Federation (IPPF)** has a project with the Ukrainian Family Planning Association (UFPA). The UFPA has 17 regional branches and about 1,300 members. The two-year project (January 1999 to January 2001) will provide general support to UFPA, training, IEC development, and capacity building for the UFPA.

- The **World Bank** has a small pilot project in the treatment and prevention of tuberculosis. It is in the process of negotiating a new health program with the MOH. Current plans are for it to have two major components: tuberculosis treatment and prevention and capacity building at the MOH. It also may include some health care reform activities.

- **Red Cross and Red Crescent Societies'** activities are mainly in the areas of disaster preparedness, feeding programs, and emergency flood relief in Western Ukraine. The Red Cross also started in early 1999 a three-year tuberculosis treatment and prevention project with the GOU.

- The **Canadian Trust Fund in Health Protection** has a pilot initiative in treating tuberculosis.

- The **Canadian Agency for International Development (CIDA)** is funding a project to develop and establish an integrated curriculum on harm reduction behavior in the schools.

- The **United Nations Children's Fund (UNICEF)** has several activities that target youth, including youth information centers, youth friendly clinics, and preventing HIV/AIDS and STDs among IDUs.

- The **Joint United Nations Programme on HIV/AIDS (UNAIDS)** received a $1 million grant from the Turner Fund to promote peer education on healthy lifestyles for young people. Other UNAIDS projects include several small HIV/STD prevention projects aimed at youth, prisoners, and IDUs.

- The **European Union** has discussed with USAID/Washington the possibility of collaborating on an HIV/AIDS program in the Ukraine.

- The **Soros Foundation** has a needle exchange program that is being implemented by several small NGOs.

- **Doctors without Borders** (Dutch) is planning to have a $1–2 million HIV/AIDS program in the Ukraine. The project is at the planning stage but it may be based on the Russian model (i.e., awareness campaigns for the general public, training programs for health professionals, and distribution of condoms from special centers). The project does not plan to procure condoms for the GOU or distribute them widely.

A few NGOs serve vulnerable or socially disenfranchised groups (IDUs, gay men, and people with HIV/AIDS) and also carry out community-based interventions, such as needle exchange and condom distribution. In addition to the NGOs, several United Nations agencies (UNICEF, United Nations Development Programme [UNDP], UNAIDS, and the World Health Organization [WHO]) as well as the Soros Foundation have provided assistance in this area, such as:

- support for IEC efforts directed at youth (UNICEF) and for the Odessa-based NGO, Trust, Hope, and Love (UNDP);

- information dissemination, risk reduction for IDUs, and regional cooperation among Eastern European nations (UNAIDS); and,

- technical assistance to the GOU for policy reform related to prevention and management of STDs, including HIV/AIDS (WHO).

II. SECTOR CONSTRAINTS

A. ACCESS AND QUALITY OF FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

Access

Access to reproductive health (RH) services (in particular family planning) through the public sector is, in theory, good, given the number of service delivery points. However, the emphasis on obstetricians/gynecologists providing modern contraception at hospitals and women's consultation clinics means that access is very dependent on specialists. Given the number of obstetricians/gynecologists in the country, this is not a problem in urban and semi-rural areas. In rural areas, however, it is more of a problem since nurses and midwives, who cannot insert IUDs, usually staff rural clinics.

Although new guidelines on family planning and reproductive health were adopted in 1999, some constraints still exist in terms of access to specific methods:

- Pills are available only by prescription, which means that they cannot be promoted or advertised generally, but only to medical personnel and pharmacies (Volodymyr, 1999). (However, it was reported that pills could be purchased without a prescription.)

- There is some confusion about who can insert IUDs. Currently, only obstetricians/gynecologists can insert IUDs (Volodymyr, 1999). However, some family health doctors are being trained in IUD insertion by JHPIEGO. This could not be verified during the fieldwork but the family health doctors could be receiving training under the auspices of a model or pilot activity.

- While some training has occurred among specialists in minilaparoscopy and laparoscopy (through AVSC), this method is not yet widely available. The number of women accepting sterilization appears to be growing slowly. According to MOH staff, most of the women accepting sterilization have medical problems.

The role of NGOs in health care and family planning is currently insignificant (Volodymyr, 1999). While charity organizations can officially assist in health care development, health promotion and health care delivery, the reality is different. Access to STD/HIV/AIDS prevention services is similarly limited to a handful of NGOs.

Contraceptives are not on the essential drug list and the GOU depends upon donors, mainly USAID and UNFPA, for contraceptives. When family planning centers run out of contraceptives, a client must purchase them from pharmacies. If she can afford them, they are readily available.

The issue of paying for services may be a barrier for all health care in the Ukraine. Patients are now expected to pay ("contribute") for services that were free, and patients need to either purchase or bring drugs and other necessary supplies when they use the services provided through the government health system (Bergthold, et al., 1998). The Ukraine is developing two classes of services within its health care system based on a patient's ability and willingness to pay.

Assessing the effect of the monetary costs on access to contraception in the Ukraine is complex because of the artificially low cost of abortion. An abortion procedure costs about $15 (late 1997 estimate) and is a safe and cheap method of fertility control. (This estimate may not include unofficial payments.) The Ukrainian legislation establishing the National Family Planning Program requires free provision of contraception (Volodymyr, 1999). As discussed earlier, the GOU relies on donors to provide contraceptives. Pills in pharmacies may cost from $2 to $5 per cycle or about $24–$60 per year, which is considerably above the cost of an abortion. Thus, if women choose to switch from having an abortion to using pills, they will incur higher costs, which of course is a deterrent to using pills to prevent pregnancy (Bergthold, et al., 1998).[6] An upcoming contraception audit sponsored by USAID may provide information on the overall availability of contraceptive commodities. Based on a late 1997 evaluation, access to condoms, in terms of an adequate supply of either low-cost or free condoms, was apparently a problem in the Ukraine (Bergthold, et al., 1998).

Reasonable access to family planning exists, but it continues to be based on a model of service delivery which places too much emphasis on doctors, specialists, and curative care and not enough on preventive care by health providers such as nurses, auxiliary health workers, as well as patient involvement and responsibility for one's own health. It will be constrained unless reproductive health is integrated into the overall health care system that increasingly emphasizes preventive care. The involvement of well-trained providers is highly appropriate for particular methods of contraception, such as sterilization and IUDs, but broad access to a variety of methods should depend on the increasing involvement of nonspecialists (family doctors, midwives, paramedics, and feldshers) and the private sector, especially for supply methods such as pills and condoms. Recent efforts to train family doctors and teams of doctors and midwives together are useful and positive steps.

While the MOH gives priority to improving services for adolescents, "access to . . . reproductive health and family planning (services) is limited. Diagnostics and treatment of sexually transmitted diseases, family planning, and drug prevention and treatment services geared toward young people are rarely available, accessible, or affordable. The lack of counseling services and the unfriendly atmosphere in the clinics that exist further alienate young people" (Cabinet of Ministers, 1997, p. 63). Access to contraception for adolescents is limited primarily to over-the-counter commodities, such as condoms.

[6] A separate issue is the relative cost of abortion versus family planning to the health system. Given the oversupply of specialists who have performed abortions, the use of their time and the related costs is not an issue. As health care becomes rationalized, the time spent by specialists performing abortions can be better used for other services (Bergthold, et al., 1998).

Since pills are viewed as a medical intervention, informed consent is required for youth under age 15. Youth 15–18 years old can obtain pills either based on their own consent or that of parents or other adult guardians. Access to abortion for youth under 18 requires the consent of parents or other adult representatives (Volodymyr, 1999).

Knowledge of contraception based on a small-scale study suggests that there is general awareness of methods, but not a good understanding of how methods work (Ukrainian Surveys and Market Research [USMR] 1998). Information about contraception comes mostly from friends and acquaintances, and there is much gossip and many prejudices about particular methods. This results in negative attitudes about the health effects of some methods that may be unwarranted. Women want information on contraception to be widely available both through mass media and at the health consultation centers. Knowledge of sources of family planning and reproductive health services is another aspect of access. Until information from the reproductive health survey becomes available, it is not possible to assess such knowledge among the general population in the Ukraine.

Psychosocial barriers are another component of analyzing access to family planning and reproductive health. The information that is available is based on small, formative research studies (USMR, 1998). Once the new RH survey data are available, it will be possible to assess reasons for using and not using a particular or any method(s) of family planning and other RH services. Existing information suggests that some women lack sufficient information about the advantages and disadvantages of different methods of contraception:

- Women do not use some methods (diaphragm, cervical cap, spermicides) because they are inconvenient and are seen as outdated and unpopular;
- Women have negative attitudes about sterilization, which is perceived to be dangerous because it is surgery;
- Women do not use newer methods, such as DepoProvera and Norplant, because they are not well informed about them; and,
- Most postabortion and postpartum women plan to use traditional methods of contraception in the future and do not see drawbacks in using such methods.

Quality

Range of Methods Available

Existing information on methods, based on the "Health-1996" survey, shows good use of modern contraception with considerable reliance on IUDs and condoms, but virtually no use of very effective long-term and permanent methods (DepoProvera and sterilization) that are very popular in many other countries. In addition, abortion rates, while declining, are still very high, suggesting that women are not using effective methods or

are not using methods correctly. The quality of services is somewhat constrained by the apparent lack of access to the full range of highly effective, modern methods.

Client-Provider Interaction

Two issues related to client-provider interaction concern who chooses a method of contraception and whether women are getting their preferred method since that apparently has bearing on continued, effective use of contraception. A small-scale study suggests that clients do not have confidence in selecting a method for themselves and thus they rely on a doctor's advice (USMR, 1998). Thus, the new emphasis on client-provider interaction should enhance a woman's role in choosing a method. There is no information on whether women obtain their preferred method, which may reflect limited attention to client perspectives of quality of care. Efforts to make the health care system more responsive to consumer or client needs, as part of the larger health care reform, might address this particular aspect of service quality. Finally, doctors say they lack time to talk at length with clients (USMR, 1998). This finding supports the need to involve nonspecialists in the delivery of services and especially in counseling.

Based on the above small-scale study, women generally have unfavorable impressions of specialists at the MOH women's consultation clinics. Women find these providers rude and incompetent in counseling and try to avoid them as much as possible. Women find obstetricians/gynecologists at maternity hospitals and abortion units to be more attentive toward their women patients.

Technical Competence

Due to training in modern contraceptive technology, the technical competence of many specialists has improved in recent years. The primary constraints on technical competence are related to ensuring that this training is replicated throughout the health care system and that sufficient training materials, including the MOH guidelines on reproductive health, job aids and contraceptive supplies and commodities, are available. In addition, and as mentioned under the discussion of access, the provision of reproductive health and especially family planning, needs to rely increasingly on the involvement of appropriately trained family doctors, nurses, midwives, and others involved in preventive and primary health care.

Information Given to Clients

Recent training efforts and the development of IEC materials (cue cards, posters, and client brochures) are helping to improve the nature of client-provider interaction. Posters, cue cards, and limited IEC materials for clients were observed at almost all of the family planning centers visited in Odessa and Lviv. However, these two oblasts are among the oblasts targeted by USAID/Kiev. The availability of IEC materials in oblasts where USAID has not been active is not known. Until such activities are pervasive throughout the health care system, quality will be constrained. There is concern that resources are not adequate to ensure wide availability of these IEC materials (Bergthold, et al., 1998).

IEC activities were concentrated on the three sites where training in reproductive health has also occurred. As with training, the benefits of these activities need to reach beyond the demonstration programs to ensure that the general population becomes better informed about contraceptive methods (especially new methods), their possible side effects and reliability. The results of the new RH survey should give useful information about the gaps in current knowledge and also communication habits of Ukrainians that could help inform any national IEC activities.

Constellation of Services

One final component of quality concerns the link between family planning services and other aspects of reproductive health, such as services for reproductive tract infections (RTIs) and STDs. Apparently, there is no close working relationship between such providers, even in municipal health systems and rural health programs (Bergthold, et al., 1998), and thus access to both services simultaneously is constrained. Current MOH job descriptions distinguish among providers and dictate who can perform which services. As health reform proceeds, attention will be needed to ensure that unnecessary barriers are not maintained about which providers are allowed to provide the array of services that constitute reproductive health.

Image of Family Planning/Population Growth

In general, the Ukraine can still be characterized as having an abortion culture, although this may be changing. The results of the new RH survey should be very useful in this regard. Based on available information, there appears to be considerable use of contraception. It is not clear whether women who resort to abortion are not using contraception at all, are using ineffective methods, or are using effective methods incorrectly. Again, the results of the new RH survey will help to answer this question as well.

There is some discussion in the Ukraine about the negative growth rate and the need for more people. At the moment, however, there does not appear to be a strong pro-nationalist movement that is pushing to increase the birth rate by restricting access to reproductive health services.

B. PUBLIC SECTOR

The Ministry of Health is currently drafting a health strategy that should be available in mid–1999. In addition, the POLICY project is assisting the MOH in the development of RH policy and the follow-on to the National Family Planning Program (NFPP), which officially concludes in 2000. Because these two documents are currently in progress, the approaches or priorities that will be addressed in each of them are not known.

The first priority in both health and reproductive health for the GOU must be finding ways to finance the health care system. As discussed above, the NFPP is a mandated program that does not provide funds to the oblasts. Several respondents mentioned that

the MOH currently only has enough funds to provide salaries for staff. In some regions, salaries were reportedly delayed due to lack of funds. USAID/Kiev is in the process of issuing an RFP for a health care financing program. This program is urgently needed and should be started as soon as possible. If the financing of the health care system is not solved, the entire system will continue to deteriorate. Because of the integration of reproductive health care into the MOH health system, the financing issue is one that affects the delivery of all health care services, including reproductive health.

C. PRIVATE SECTOR

Private/Commercial Sector

In a country like the Ukraine, where the MOH cannot afford to continue to provide free health care services and pharmaceuticals to the entire population, the role of the private sector becomes very important. The scale and apparent ubiquity of private, out-of-pocket payments for health care services suggest a widespread acceptance of private medicine among both the population and health care professionals alike. Just as many state physicians accept, and perhaps expect or even demand unrecorded, unofficial fees from their patients, many patients are willing or expect to pay for services that, in theory, are supposed to be provided free of charge. (Hauslohner and Burgess, 1996). Patients are already expected to purchase pharmaceuticals.

Numerous attempts at fee for service or paid health insurance were tried under the Zdrav*Reform* project and by private individuals. Some apparently failed due to a lack of a supportive legal environment. For example, several physicians planned to form a group practice that would contract with the local polyclinic to deliver services. The physicians dropped the idea because they were not sure it was legal. In Lviv, a group of physicians has developed a private insurance plan that has been approved by both city and oblast health officials. Clients would pay approximately $2.50 a month for services, including drugs and contraceptives. Only very minor operations would be included. The physicians, however, do not have the funds for a media campaign to attract clients. Odessa has a private clinic that was established approximately 10 years ago which delivers outpatient services and provides free services for certain “social patients.” The owner of the clinic claimed that the clinic’s caseload was increasing but not its profit.

The private/commercial sector includes private pharmacies where a range of contraceptives is available. The private sector has few private practicing physicians. Private dental care appears to be the most prevalent health care provided in the private sector.

The potential role for the private/commercial sector needs to be recognized by the GOU. In addition, the necessary legal and regulatory policies need to be in place to encourage the private sector.

Nongovernmental Organizations

Some of the nongovernmental organizations in the Ukraine, although small, are very active and appear to attract dedicated volunteers. The USAID/Kiev Counterpart Alliance is working to strengthen these organizations and numerous donors are funding them to work with sex workers, drug users, and adolescents in the areas of HIV/AIDS and STD prevention. The role of the traditional small NGO with a narrow scope, at least in the short term, will probably be limited to providing information, counseling, and education on various topics, including reproductive health. Some distribute condoms to sex workers and drug users.

The Ukrainian Family Planning Association (UFPA), with 17 regional branches and about 1,300 members, is the largest NGO family planning association in the Ukraine. The UFPA is an IPPF affiliate and receives funding for training, support of the organization, and IEC development.

III. SECTOR STRATEGY

The sector strategy presented here includes a few general guidelines to help USAID/Kiev define priorities for reproductive health and how reproductive health (RH) efforts fit within the larger health strategy. More specific guidance is presented in the strategic approach to RH for future technical assistance to both public and private health sectors and for particular functional areas within each sector, including policy development, training, and IEC.

A. General Guidelines

Priority Areas in Reproductive Health

Reproductive health should continue to be a priority for USAID assistance in health. While the overall prevalence of contraceptive use appears to be reasonably high and the abortion rate is declining, the level of abortion is still one of the highest in the world. Attitudes about and use of modern methods of contraception point to important gaps in the access to and quality of family planning services. Levels of morbidity due to sexually transmitted diseases are increasing, and the number of HIV/AIDS cases has risen sharply, indicating a serious epidemic in the making. These trends also suggest the critical need to prevent STD/HIV/AIDS.

Five possible foci of future USAID assistance in reproductive health in the Ukraine to be considered include: 1) family planning, 2) safe pregnancy (including prevention of abortion and postabortion care), 3) breastfeeding, 4) adolescent reproductive health, and 5) STD/HIV/AIDS prevention. Pending the results of the planned RH survey, there is a need for continued emphasis on increasing access to a wide range of contraceptive methods, prevention of abortion and postabortion care, and prevention of STD/HIV/AIDS. Promotion of breastfeeding has benefited from the family-centered maternity care units and the postpartum rooming-in policy and no longer needs to be a priority for USAID–supported technical assistance and training. The area of adolescent reproductive health receives considerable attention from other donors (e.g., CIDA, UNAIDS, and UNICEF) and need not be a priority of USAID.

Recommendation No. 1: Reproductive health should continue to be a priority for USAID assistance in health and there should be three priority areas within reproductive health: family planning, abortion prevention, and prevention of STD/HIV/AIDS.

Strategic Objectives and Intermediate Results in Reproductive Health

The Strategic Objectives (SOs) and possible performance indicators for each of the three priority areas are presented in the table below. While a more general SO, such as "improved reproductive health services," would be more similar to SO 4.1 as presented in the USAID/Kiev Health Strategy, more specific strategic objectives are preferable. For SOs 1 and 3, several performance indicators are included. In the case of SO 1, there is a

direct link between the objective of increased use of modern contraception and preventing abortion in SO 2; thus, some of the indicators will help assess whether the reasons for women resorting to abortion are changing.

Table 2
Reproductive Health Strategic Objectives for 1999–2002

Strategic Objectives	Performance Indicators	Data Source
1. Increased use of modern contraceptives	▪ Percent of population using modern methods	CDC, DHS* or other population-based survey
	▪ Contraceptive failure and discontinuation rates	
	▪ Percent of pregnancies that were unwanted and mistimed[7]	
	▪ Attitudes about contraceptive methods	
2. Reduced use of abortion	Abortion rate[8]	GOU statistics
3. Increased use of preventive interventions to reduce STD/HIV/AIDS	▪ Percent of population (male and female) reporting low-risk sexual behavior for STD/HIV/AIDS	CDC, DHS or other population-based survey
	▪ Percent of population of reproductive age reporting condom use: a) in-union partners relations and b) casual partner relations	CDC, DHS or other population-based survey
	▪ STD prevalence rates and number of HIV/AIDS cases (in target population)	GOU statistics

*DHS: Demographic and Health Survey

[7] Typically, in states of the former Soviet Union, very few unplanned pregnancies result in a live birth because women abort such pregnancies. If births are unwanted or mistimed, one can assume one of three reasons: a) no use of contraception to prevent pregnancy, b) use of ineffective methods that, by definition, have high failure rates, or c) incorrect use of effective methods. Thus, this indicator may be considered a proxy for access to family planning (access implies knowledge of where to get different contraceptive methods) and effective use of modern methods (which implies a good understanding of different methods).

[8] It may also be useful to look at the proportion of mini-abortions to standard abortions since the former are often associated with fewer complications and are performed as an outpatient procedure, thus requiring fewer health resources.

The following Intermediate Results are for illustrative purposes because the focus of the technical assistance will determine which indicators should be used.

Table 3
Intermediate Results, Indicators, and Data Sources

Intermediate Results	Performance Indicators [9]	Data Source
Expanded access to RH in public sector	▪ Percent of health posts or service delivery points (SDPs) in target oblasts that provide RH services ▪ Percent of health posts or SDPs that are stocked with contraceptives and antibiotics (for STDs) ▪ Percent of health providers trained in RH in target oblasts	Facility survey or GOU administrative statistics
Improved policy environment for RH as part of overall health reform	▪ Percent of health budget devoted to RH ▪ Existence of official policy statement or document on RH	GOU statistics and records
Completed institutionalization of RH training	Indicators will depend on the results of the training assessment and the specific focus of future technical assistance	
Increased public IEC about RH	▪ Percent of population in target oblasts who have favorable attitudes about modern contraceptive methods ▪ Percent of population in target oblasts who are knowledgeable [10] about modern contraceptive methods ▪ Percent of population in target oblasts who know how STD/HIV/AIDS are transmitted ▪ Percent of population in target oblasts who know how to prevent STD/HIV/AIDS	CDC, DHS or other population-based survey
Increased availability of condoms for STD/HIV/AIDS prevention	Percent of health posts or SDPs in target oblasts stocked with condoms	Facility survey or GOU statistics
Increased role for private sector in delivery of RH services	▪ Percent of users of family planning who get methods from private sector ▪ Level of commercial sales of contraceptive methods or couple year protection (CYP) ▪ Number of social marketing campaigns	CDC or other population-based survey Commercial sales records CMS project data

[9] Most of these are process indicators, not outcome indicators.

[10] Knowledge here does not refer to simple awareness of different methods, but rather correct knowledge of the advantages and disadvantages of different modern methods, and knowledge of sources of these methods.

Integration of Reproductive Health into USAID/Kiev Health Strategy

In the Ukraine, reproductive health must be viewed in the context of the entire health care system, including the future evolution of public and private health care. Integration of reproductive health into health care services should be the norm and the goal. The emphasis on preventive medicine and primary health care, as defined in USAID/Kiev's Health Strategy (USAID, 1998), allows for an appropriate and feasible integration of reproductive health services, particularly in terms of public sector services. Furthermore, the Health Strategy defines primary health care broadly enough to include the three priority areas of reproductive health (". . . prevention of disease, . . . maternal and child care, including family planning, . . ."). However, the integration of reproductive health should be made more explicit in the Health Strategy, given the current reproductive health needs in the Ukraine. In addition, a reproductive health component should be included in all Mission health activities, such as the AIHA model primary health care centers and the planned health care financing project.

The Health Strategy has six different elements that combine both functional areas, such as service delivery, training, financing, and policy development with different health issues or problems, such as healthy lifestyles and environmental and occupational risks. Integrating reproductive health into this strategy would involve ensuring that the above-mentioned functional areas always include reproductive health as a priority. Based on past work in setting up demonstration sites for service delivery that include RH services, there will be continued work to ensure that such services are sustained. Past work to establish family doctors and the new plans for work in primary health care are appropriate service strategies that can readily incorporate RH as a priority. Similarly, RH needs to be an integral part of the training, financing, and policy development activities that are undertaken. Since considerable training in RH has already occurred, there may be ways for more general training in health to benefit from some of the experiences in the RH area. Work in financing and policy development will undoubtedly involve a broad scope, and ensuring that RH is considered in the agenda for both assistance areas will be important. The Health Strategy's emphasis on healthy lifestyles and promoting health and prevention is quite suited to the SOs in RH, which are also based on a preventive approach to good health. There is no obvious link between RH and environmental/occupational risks.

Several additional factors should be taken into account before USAID/Kiev officially adopts or begins to implement its proposed Health Strategy. First, the results of the RH survey will be available in September or October and may provide new information on RH needs and thus for the proposed RH strategy. Second, two key donors are currently developing new assistance programs: the World Bank is developing a health project and UNFPA is developing its new RH program. USAID may want to review its proposed strategy in light of the other donors' plans. Third, the broad focus of the current Health Strategy may be somewhat unrealistic, given the level of resources available from USAID/Kiev in the health area. Since the Mission is now preparing an RFP for the new health care financing project, the level of effort and funding needed to implement this project will also affect what is feasible under the general Health Strategy. Finally, the USAID/Kiev Health Strategy acknowledges the potential for the private sector in health

care, but it is largely silent on how USAID assistance could stimulate the involvement of the private sector, except in general terms within the legal/policy environment. Greater attention might be given to the private sector in this strategy, assuming an integration of RH into the overall Health Strategy, and given the recommendation in this report that the commercial private sector be engaged in reproductive health, and the recognition that a number of USAID–assisted NGOs are already involved in the prevention of STD/HIV/AIDS and will likely be more involved in the future.

Recommendation No. 2: The USAID Strategic Plan for the Ukraine, Strategic Objective 4.1, Improved Health Care Service Delivery, should be revised to include reproductive health as a specific component and that several of the performance indicators suggested in the table above be considered for adoption in the plan. Also, the Mission should review its proposed Health Strategy in the next 4–6 months to take advantage of new information that will be available as other donors clarify their priorities for health assistance and to develop a fully integrated health and RH strategy. (If the Mission approves this recommendation, it is suggested that this reproductive strategy only be considered a working draft and funds not be expended on having it edited or reproduced for wide distribution.)

The specific recommendations outlined below under the Strategic Approach in Reproductive Health should be considered until an integrated health/reproductive health strategy is developed. Since the proposed approach builds on past and current USAID assistance and also reflects the current environment surrounding health and reproductive health care in the Ukraine, it is possible to proceed to carry out the recommendations.

B. STRATEGIC APPROACH IN REPRODUCTIVE HEALTH

The strategic approach for the three priority areas in RH identified above involves continued engagement of the public sector and strengthening the private sector. To promote family planning and prevent abortion, recommendations are made for policy development (in reproductive health and also more general health policy), additional training to fill gaps in RH training efforts, and reproduction and possibly development of IEC materials. Work with the private sector is envisioned both in terms of RH (specifically family planning) but also health care service delivery more generally. USAID/Kiev, with USAID/G/PHN/HN/HIV–AIDS assistance, is currently drafting a proposal that may be the basis for the Mission's future work with both the public and private sectors in preventing STD/HIV/AIDS.

Public Sector

<u>Policy Development</u>

The POLICY project is currently working in the Ukraine to strengthen the legal and regulatory framework for the delivery of health services. The recommendations below are not intended to focus only on reproductive health but to concern the health sector as a whole. It is recommended that the POLICY project scope of work be expanded to form and chair a committee on policy coordination, to assist the Mission in developing a policy dialogue agenda, and to work more at the oblast level.

- **Policy Coordination Committee:** This committee would be chaired by the POLICY project advisor and would be made up of U.S. cooperating agencies (CAs) that have a stake in the development of policies, regulations, and laws in the health area. The mandate of the committee would not be limited to reproductive health but would include the broader issue of health care in the Ukraine. Members would include representatives from AIHA, the health care financing reform project, the Commercial Market Sector (CMS) project, USAID/Kiev, and other projects as appropriate. For certain issues, it may be appropriate to invite other USAID/Kiev project representatives (e.g., the Parliamentary Development project). Also, other donors may be invited to attend meetings that address common issues.

- **Policy Dialogue Agenda for USAID/Kiev:** How health policy evolves in the current changing environment will affect the development of an equitable health care system. The Ministry of Health will have a proposed new structure at the end of May 1999 and the new Health Strategy should be completed by September 1999. In addition, USAID may be implementing new projects (Health Care Financing and Commercial Market Sector). How these factors come together and the impact that changing or not changing policies, regulations, and laws has on the delivery and financing of health care services in both the public and private sector needs to be understood and discussed with the MOH and other appropriate GOU officials. The POLICY project will assist the Mission in developing a policy dialogue agenda. It may be possible for the policy dialogue to be carried on at several levels (i.e., the U.S. Ambassador, the USAID/Kiev Mission Director, and the Office of Democracy and Social Transition [DST]). The policy dialogue agenda could also include items for discussion with other donors and partners.

- **Work with and assist policy development at the oblast level**. The POLICY project should expand its work beyond Odessa to assist other CAs, especially AIHA and the new primary health care centers, which will be working at the oblast level to address policy and advocacy issues.

Recommendation No. 3: The Mission should consider expanding the scope of work and funding for the POLICY project to include, at a minimum, the development of a policy agenda for the Mission, working at the oblast level, and establishing a policy coordination committee. The duration of activities should be for at least three years.

Training

Training has been carried out by numerous cooperating agencies (AVSC, JHPIEGO, PCS) and donors. While the efforts were coordinated to some extent, it is unclear exactly what additional training is needed. The UNFPA is currently developing a new program that will include a component for training nurses and midwives in reproductive health. Also, the planned World Bank project may have training activities. The new model primary health care (PHC) centers' partnerships (AIHA) will include training of service providers. (With the limited time available during the site visits, the assessment team did not have time to conduct a thorough assessment of training. It did appear, however, that some overlap is occurring.)

The Mission should conduct a training assessment to identify gaps in training and to ensure that the training complements the new integrated health/reproductive health strategy. The assessment should look at the extent of the training, such as types of persons trained, training content, oblasts or regions in which training was conducted, and whether sufficient training materials and job aids have been provided by USAID/Kiev and other donors. Given the new emphasis on primary health care and prevention, particular attention should be paid to possible gaps in reproductive health training for nonspecialists, such as family doctors, nurses, midwives, and feldshers. The impression is that oblasts have been conducting second and third generation training. However, to what extent this is occurring in every oblast where USAID/Kiev has provided training is not known and should be part of the training assessment.

USAID is currently concentrating its work in five or six oblasts. The decision to expand training to other oblasts is a decision that should be made based upon the receptivity of the oblasts to reproductive health training, the willingness and ability of the oblasts to conduct second and third generation training, and the availability of USAID/Kiev resources. If USAID/Kiev decides to expand beyond the current oblasts in which it is working, it should select two or three oblasts for the assessment team to consider for possible expansion of training.

Recommendation No. 4: The Mission should conduct a training needs assessment.

JHPIEGO has assisted the GOU in incorporating reproductive health and family planning into the curricula of the refresher institutes of the obstetricians/gynecologists, nurses and midwives. It is recommended that they complete the process for incorporating reproductive health into the refresher training for family doctors. Also, it is recommended that JHPIEGO assist the GOU in incorporating/revising the reproductive health/family planning component in the preservice curriculum of nurses and midwives. Since JHPIEGO has begun the process for incorporating reproductive health into the refresher training for family doctors, it should be able to complete both in one year. If this time frame is unrealistic, the Mission should consider extending JHPIEGO's scope of work for another year.

Recommendation No. 5: The Mission should fund JHPIEGO for one additional year to assist the GOU in incorporating reproductive health and family planning into the

curriculum of the refresher institute of family medicine physicians and the preservice curriculum for nurses and midwives.

STD/HIV/AIDS

As discussed in preceding sections in some detail, the HIV/AIDS problem in the Ukraine is spreading. One consistent lesson from the global HIV pandemic is that HIV never remains confined to one risk group or social strata (Lifson and Preble, 1997). Evidence of that fact seems to be appearing in the Ukraine. USAID/Kiev and USAID/Washington are developing an STD/HIV/AIDS strategy for the Ukraine. USAID/Kiev should fund STD/HIV/AIDS activities with the following caveats:

1. Update the November 1997 assessment to determine activities of other donors and organizations. It appears that while numerous activities/programs in HIV/AIDS are being implemented, there is little cooperation or coordination among the donors. Also, some of the smaller NGOs can absorb a limited amount of funding.

2. Involve the GOU in the design of the program to ensure its commitment.

3. Include a policy component to assist the GOU in addressing the HIV/AIDS issue. Working with the GOU to develop policy and to confront the problem appears to be a gap that other donors are not filling.

4. Consider procuring the excess USAID/Washington condoms.

5. Consider providing condoms to the GOU and other organizations for targeted groups. Other donors involved in STD/HIV/AIDS programs only provided condoms for their programs. Almost no condoms were found at the MOH facilities visited during this assessment. (Note: The recommendation is not that USAID/Kiev provide the GOU condoms on a long-term basis. It may be necessary, however, to provide condoms to the GOU in the short term to engage it in the STD/HIV/AIDS issue.)

6. Discuss with other donors the possibility of providing sufficient condoms to the GOU.
7. Consider doing a condom social marketing campaign in the Ukraine that includes media campaigns on promoting condom use, especially among the high-risk groups.

Recommendation No. 6: The STD/HIV/AIDS strategy currently being developed by USAID/Kiev and USAID/Washington should include consideration of other donors' programs, involve the GOU in the design of activities, include a policy component, and consider a condom social marketing activity. Also, USAID/Kiev should procure the excess USAID/Washington condoms for use in the HIV/AIDS program in Ukraine.

Private Sector

Strengthen the Delivery of Services in the Private Sector

The GOU does not have sufficient resources to maintain the current health care system. The commercial, private and nonprofit sectors, however, have the potential to be partners to the GOU in the delivery of health care services. As discussed above in section II, in order for the private sector to become a partner, the necessary legal and regulatory framework must be in place.

USAID/Kiev should consider a set of activities that would strengthen the delivery of services in the private sector. The new Commercial Market Sector (CMS) project should be ideal for working in the Ukraine on this issue. The project, along with the Health Care Financing project, would assist the GOU in improving the policy, regulatory and legal environment and administrative practices constraining the commercial market sector, and to rationalize its mix of public/private resources in the delivery of health care services. The activities would also support development of private delivery networks and test private health care financing mechanisms by working with private associations, such as the Private Physicians Associations in Odessa and Lviv, NGOs, the commercial and nonprofit sectors, and pharmacists' associations.

The CMS project should conduct an assessment of the potential for the delivery of health care services by the private sector. Also, the CMS project should continue the training of pharmacists started under the SOMARC project.

IEC

The CMS project could also be a vehicle for the reproduction of IEC materials. JHPIEGO, PCS, and SOMARC, as well as other donors, have produced materials for women and service providers. If additional materials are needed, the CMS project should reprint some of the materials already developed and tested. The Mission should decide, based on information from the RH survey, if specific targeted IEC materials and national IEC campaigns are needed. The CMS project scope of work would allow them to also carry out these IEC activities.

Recommendation No. 7: The Mission should conduct an OYB transfer to the CMS project for conducting an assessment of the potential for the delivery of health care services in the private sector, continuing the training of pharmacists, and reproducing IEC materials.

ISSUES

Donor Coordination

In the health sector, donor coordination is weak. As the donors plan and implement programs, it is important that they cooperate and coordinate with each other. This is especially essential in reproductive health, HIV/AIDS, and health care financing. The

UNDP representative volunteered to take the initiative on starting a working group on health.

Recommendation No. 8: USAID/Kiev should encourage the UNDP to form and coordinate a donor working group on health.

Cooperating Agencies (CAs) Coordination

Several complaints about the lack of CA cooperation and coordination were reported to the assessment team during the site visits. With the current and expanding portfolio, the integration of health and reproductive health, and the proposed expanded role of the private sector, it is very important that USAID/Kiev ensure cooperation among the CAs. The policy coordination committee will be a good start; however, it is only a beginning. Lessons learned from other attempts at cooperation, such as the AVSC lead agency experience under the Women's Reproductive Health Initiative (Bergthold, et al., 1997) should be incorporated into CAs' mandates.

ANNEXES

ANNEX A

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ANNEX B

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